DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 00-27

2. STATE: NC

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
October 1, 2000

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☒ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☐ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
Social Security Act 1915 (g)

7. FEDERAL BUDGET IMPACT:
a. FFY 2000-2001 $ 0
b. FFY 2001-2002 $ 0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment I to Supplement I of Attachment 3.1-A Part D con't

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment I to Supplement I of Attachment 3.1-A Part D con't

10. SUBJECT OF AMENDMENT:
Case Management Services (Substance Abusers)

GOVERNOR'S REVIEW *(Check One)*:

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:
H. David Bruton, MD

14. TITLE:
Secretary

15. DATE SUBMITTED:
December 21, 2000

16. RETURN TO:
Office of the Secretary
Department of Health & Human Services
2001 Mail Service Center
Raleigh, North Carolina 27699-2001

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
December 29, 2000

18. DATE APPROVED:
July 23, 2001

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
October 1, 2000

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:
Eugene A. Kramer

22. TITLE:
Associate Regional Administrator
Division of Medicaid and State Operations

23. REMARKS:

FORM HCFA-179 (07-92)

Instructions on Back

(b) The patient has a diagnosis of alcohol or other drug abuse or addiction included in ICD-9-CM classification and at least one of the following:

(i) Serious behavior problems with a duration of more than one year or projected to continue for more than one year; or
(ii) Needs more than two services from mental health or substance abuse agencies; or
(iii) Has been served in a hospital or residential treatment setting or needs such services.

4. Case management under this proposal will not be provided to home and community based waiver participants. Case management transitional care activities can be performed in a Psychiatric Residential Treatment Facility for children/youth under 21 years of age 180 days prior to the estimated date of discharge.

D. Definition of Services

Case Management services include:

1. Assessment and periodic reassessment, to determine types and amounts of services needed;

2. Development and implementation of an individualized case management service plan;

3. Consistent with SSA 1902(a)(23), identification of all available resources for problem resolution;

4. Consistent with SSA 1902(a)(23), coordination and assignment of responsibilities among staff and service agencies; and

5. Monitoring and follow-up to ensure that services are received and are adequate for the client's needs.